

Metrics; the Results Dependent upon Collection



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Objectives

- ▶ Review the methods that generate self-reported measures that are required for quality submission for performance reimbursement (Medicare SSP, commercial payers, Medicaid).
- ▶ How much can be automated, how much is manual, how do you address the issue of multiple EHRs? How scalable are the options for population management?
- ▶ Describe the methods for ensuring reliability and validity of the data demonstrating integrity of data.
- ▶ Describe how the data is used to support quality improvement efforts.



Operationalization of Care Coordination

Population Health Management

Care Coordination is the Key!

Hospice/Palliative Care

Home Care Management

Provides in-home medical and palliative care management by Specialized Physicians, Nurse Care Managers, and Social Workers for chronically frail seniors that have physical, mental, social, and financial limitations that limits access to outpatient care, forcing unnecessary utilization of hospitals.

High-risk Clinics and Care Management

Intensive one-on-one physician/nurse patient care and case management for the highest risk, most complex of the population. As the risk for hospitalization is reduced, patient is transferred to Level 2. Physicians and Care Managers are highly trained and closely integrated into community resources, physician offices or clinics.

Complex Care and Disease Management

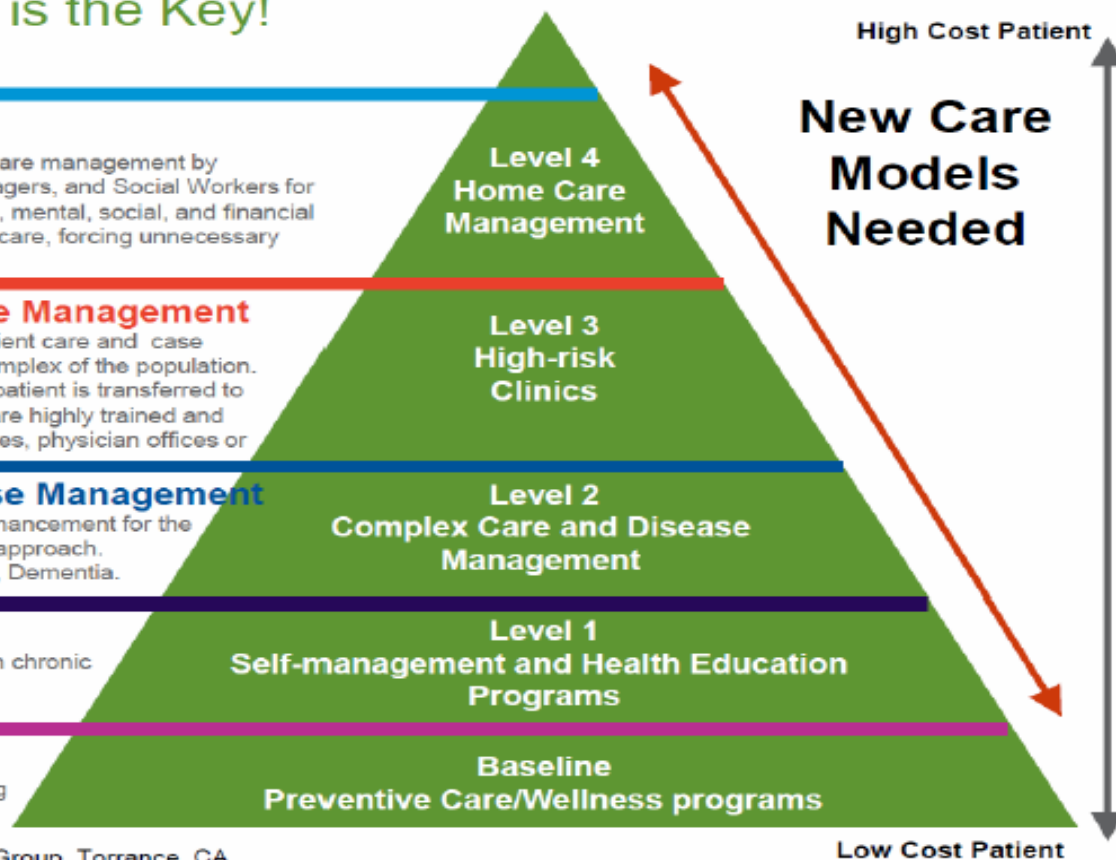
Provides long-term whole person care enhancement for the population using a multidisciplinary team approach. Diabetes, COPD, CHF, CKD, Depression, Dementia.

Self-management, PCP

Provides self-management for people with chronic disease.

Population Monitoring

Preventive care, education and monitoring for the community.



Source: HealthCare Partners Medical Group, Torrance, CA



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Managing Populations



Connect

- Acquisition and aggregation of clinical & financial data to create a holistic view of the patient



Analyze



- Physician profiling to assess efficiency and optimize network performance
- Analytics to financially and clinically risk stratify patients
- Cost and utilization management across key contract success drivers, such as drug management, leakage management, and readmissions
- Gap in care identification and registries for actionable workflows



Intervene



- Outreach workflow to proactively address patient gaps in care
- Care planning and adherence management
- Optimizing clinical and financial outcomes



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Information Technology

- ▶ If you do not measure it, you cannot improve it!
- ▶ IT is the backbone of the clinically integrated network's value proposition
 - Critical to improving coordination and enhancing connectivity between providers
 - Today, the industry is inundated with tools to help monitor and report patient care
 - Two types of data sharing sources
 - Health records and patient registries
 - Sources
 - Physician office
 - Hospital
 - Ancillary or ambulatory care facilities
 - Laboratory, radiology



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Quality Metrics - Example

▶ Acute and Chronic Care Management Measure

- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with URI
- Appropriate antibiotic treatment for acute bronchitis
- New episode of depression: acute phase treatment
- New episode of depression: continued treatment
- AMI: persistence of beta-blocker treatment after a heart attack
- CAD: ACE inhibitor/ARB therapy
- Complete lipid profile for patients with CV conditions
- Heart failure (HF) : beta-blocker therapy
- PDC: for HTN (ACEI or ARB)
- PDC: for cholesterol (Statins)
- Diabetes: eye exam
- Diabetes: hemoglobin A1c testing
- Diabetes: lipid profile
- Diabetes: urine protein screening
- PDC: oral diabetes
- Annual monitoring on persistent medications: ACE/ARB
- Annual monitoring on persistent medications: anticonvulsants
- Annual monitoring on persistent medications: digoxin
- Annual monitoring on persistent medications: diuretics
- Arthritis: disease modifying therapy in rheumatoid arthritis
- Osteoporosis management in women who had a fracture
- Use of appropriate medications for asthma

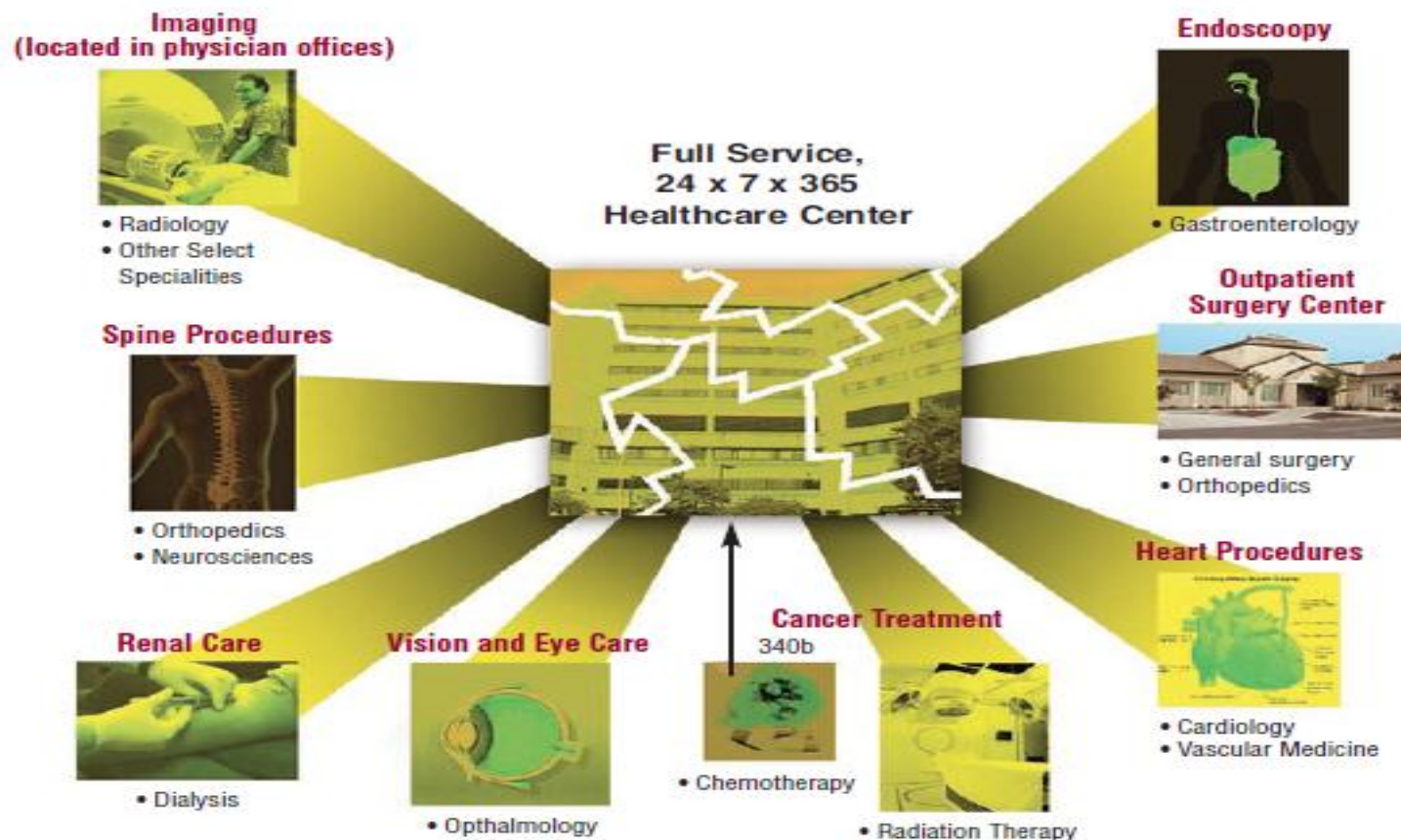
▶ Preventive Care Measures

- Well-child visits: 3-11 years
- Well-child visits in the first 15 months of life
- Childhood immunization status: VZV
- Childhood immunization status: MMR
- Adolescent well visits: 12-21 years
- Glaucoma screening in older adults
- Chlamydia screening in women
- Cervical cancer screening
- Breast cancer screening



Disaggregation of Data

Hospital Disaggregation Risks

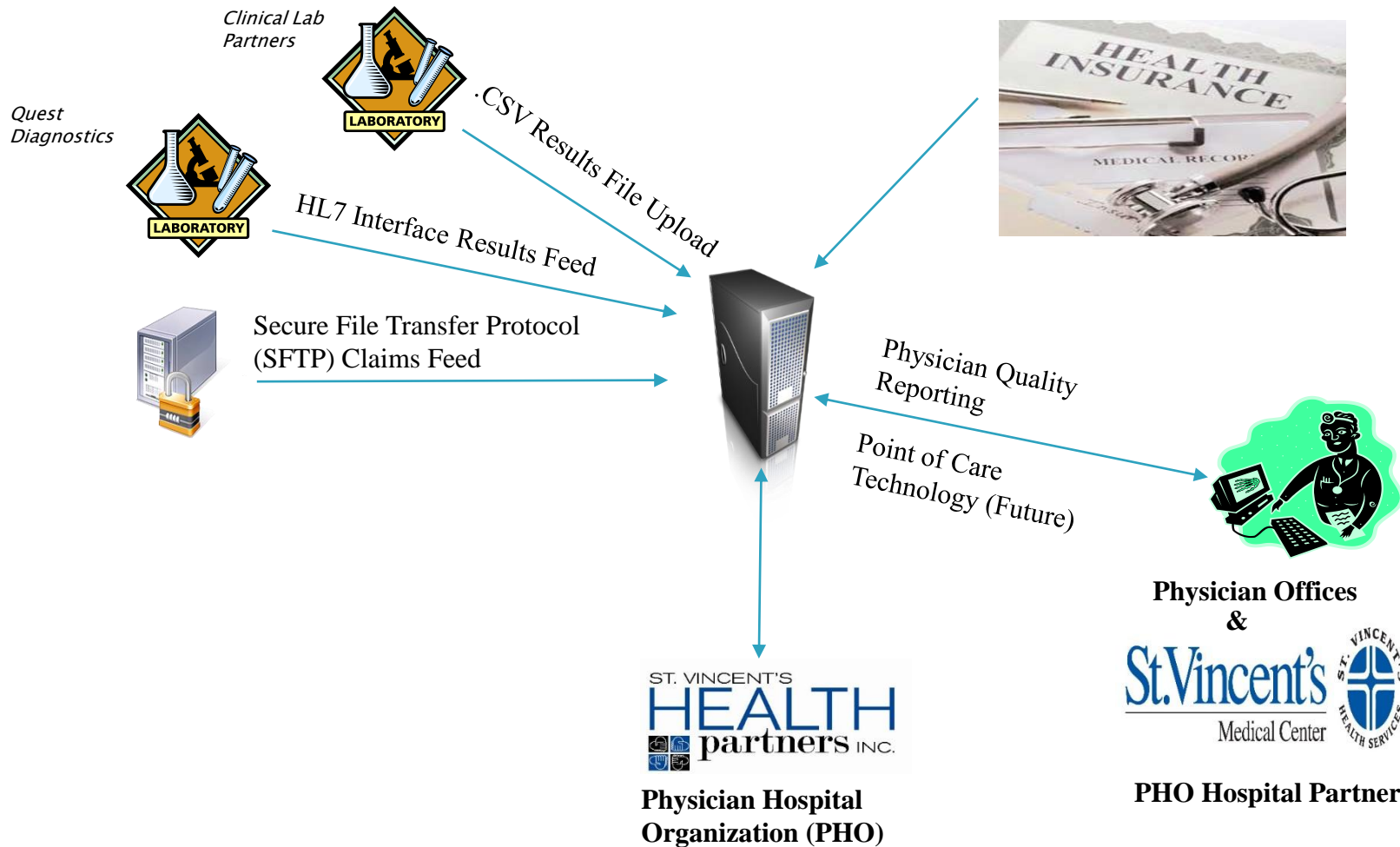


Source: Navigant Consulting



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Data Sources



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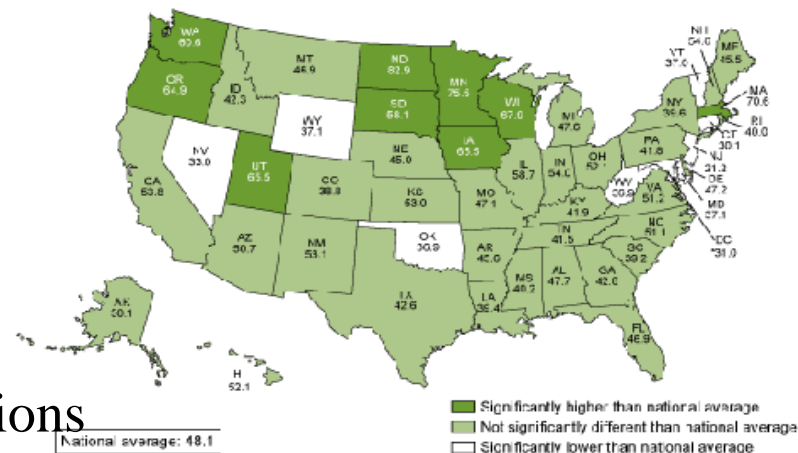
Data Challenges

▶ Data Types

- Labs not based on LOINC
 - Need for mapping between organizations
- ICD 9, ICD 10, CPT
- Discrete

▶ Data Receptivity

- Format – HL7, CCDA, Flat File
- Interface



Metrics; Meeting the Reimbursement Model

Measure	Private Plan A	Private Plan B	Private Plan C	MSSP	NCQA ACO	Meaningful Use	Buying Value	MAP Duals Family	HEDIS 2014
Breast Cancer Screening	X	X	X (42-69 years of age)	X	X		X		1
Chlamydia Screening	X (16-25)		X		X	X	X (women 16-24 years of age)		1
Controlling High Blood Pressure		X (ACE Inhibitor/Angiotensin Receptor Blocker--ARB--	CAD: patient(s) with CAD and diabetes and/or CHF		X		X (Blood pressure control)	1	
Cervical Cancer Screening	X	X			X		X	1	1
Childhood Immunization status	X (childhood immunization status combo 2)	X (MMR & VZV)			X	X	X		1
Appropriate treatment for children with upper respiratory infection	X (3 months-18 years old)	X	URI--patients that did not have a prescription for an antibiotic on or three days after the		X	X	X avoidance of inappropriate use		1
Use of High Risk Medications in the Elderly					X	X	X	1	1



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Measuring the Triple Aim: CMS Final Rule – 33 MSSP Measures



Measure Category	Number of Measures	Measure Steward	Measure (abbreviated names)
Preventive Health (8 Measures)	3	NCQA (2 HEDIS measures)	Colorectal & Breast CA Screening; Pneumococcal Vaccine
	3	CMS	Adult Weight, Depression & Blood Pressure Screening
	2	AMA-PCPI	Influenza Immunization; Tobacco Use Assess/ Cessation
At Risk Population (12 Measures)	5	MN – Community Measurement	DM A1c, LDL, BP Control, Tobacco non-use & Aspirin Use
	4	NCQA (2 HEDIS measures)	DM A1c Poor Control; HTN BP Control; IVD LDL Control, Use of Aspirin
	3	CMS / AMA-PCPI	HF Beta-Blocker for LVSD ¹ ; CAD Rx for LDL control, ACE or ARB CAD and DM and/or LVSD
Patient/Care Giver Exp (7 Measures)	7	AHRQ	Clinician & Group CAHPS Survey: Composites of 80+ Qs
Care Coordination / Patient Safety (6 Measures)	2	AHRQ ACSC	Ambulatory Sensitive Conditions Admissions: COPD & HF
	1	CMS	PCP EHR Incentive Program Reporting (Meaningful Use)
	1	CMS	Risk-Standardized All-Cause Re-Admission
	1	NCQA (not a HEDIS measure)	Medication Reconciliation after Discharge from IP Facility
	1	AMA-PCPI/ NCQA	Screening for Fall Risk
Shared Savings			



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ACO Metrics, Getting the Data

ACO Measure	Domain	Measure	NQF Measure	Method of Data Submission
1	Patient/Caregiver Experience	CAHPS: Getting Timely Care, Appointments, and Information	5	Survey
2		CAHPS: How Well Your Providers Communicate	5	Survey
3		CAHPS: Patients' Rating of Provider	5	Survey
4		CAHPS: Access to Specialists	5	Survey
5		CAHPS: Health Promotion and Education	5	Survey
6		CAHPS: Shared Decision Making	5	Survey
7		CAHPS: Health Status/Functional Status	6	Survey
8	Care Coordination/ Patient Safety	Risk Standardized All Condition Readmission	1789	Claims ADT Feed, PMS
9		Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults (ACO version 1.0)	275	Claims ADT Feed, PMS
10		Ambulatory Sensitive Conditions Admissions: Heart Failure (HF) (ACO version 1.0)	277	Claims ADT Feed, PMS
11	Preventive Health	Percent of Primary Care Physicians who Successfully Qualify for an EHR Incentive Program Payment	CMS	EHR Incentive Program Reporting
12		Medication Reconciliation	97	GPRO Web Interface
13		Falls: Screening for Future Fall Risk	101	GPRO Web Interface
14		Influenza Immunization	41	GPRO Web Interface
15		Pneumococcal Vaccination for Patients 65 Years and Older	43	GPRO Web Interface
16		Body Mass Index (BMI) Screening and Follow-Up	421	GPRO Web Interface
17		Tobacco Use: Screening and Cessation Intervention	28	GPRO Web Interface
18		Screening for Clinical Depression and Follow-Up Plan	418	GPRO Web Interface
19		Colorectal Cancer Screening	34	GPRO Web Interface
20		Breast Cancer Screening	31	GPRO Web Interface
21		Screening for High Blood Pressure and Follow-Up Documented	CMS	GPRO Web Interface
22	At Risk Population—Diabetes	Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Hemoglobin A1c Control (8 percent)	729	GPRO Web Interface
23		Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Low Density Lipoprotein Control	729	GPRO Web Interface
24		Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: High Blood Pressure Control	729	GPRO Web Interface
25		Diabetes Composite (All or Nothing Scoring): Tobacco Non-Use	729	GPRO Web Interface
26		Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease	729	GPRO Web Interface
27		Diabetes Mellitus: Hemoglobin A1c Poor Control	59	GPRO Web Interface
28		Hypertension (HTN): Controlling High Blood Pressure	18	GPRO Web Interface
29		Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (100 mg/dL)	75	GPRO Web Interface
30		Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	68	GPRO Web Interface
31		Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	83	GPRO Web Interface
32		Coronary Artery Disease (CAD) Composite (All or Nothing Scoring): Lipid Control	74	GPRO Web Interface
33		Coronary Artery Disease (CAD) Composite (All or Nothing Scoring): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF 40%)	66	GPRO Web Interface



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CMS Regions

HHS Regions

Region Number	Region Name	Covered States
1	Boston	Connecticut, Maine, Rhode Island, Massachusetts, New Hampshire, Vermont
2	New York	New Jersey, New York, Puerto Rico, Virgin Islands
3	Philadelphia	Delaware, Maryland, Virginia, District of Columbia, Pennsylvania, West Virginia
4	Atlanta	Alabama, Georgia, Mississippi, South Carolina, Florida, Kentucky, North Carolina, Tennessee
5	Chicago	Illinois, Michigan, Ohio, Indiana, Minnesota, Wisconsin
6	Dallas	Arkansas, New Mexico, Texas, Louisiana, Oklahoma
7	Kansas City	Iowa, Missouri, Kansas, Nebraska
8	Denver	Colorado, North Dakota, Utah, Montana, South Dakota, Wyoming
9	San Francisco	American Samoa, California, Hawaii, Arizona, Guam, Nevada
10	Seattle	Alaska, Oregon, Idaho, Washington



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Adult BMI

2014 Commercial Benchmarks and Thresholds

Commercial Adult BMI Assessment

Benchmark and Thresholds *(no change from 2013)*

HHS REGION	PERCENTILES			
	90th	75th	50th	25th
1	NA	82	69	45
2	NA	76	57	46
3	NA	72	58	52
4	NA	62	52	4
5	NA	81	69	54
6	NA	69	57	4
7	NA	74	62	5
8	NA	78	58	4
9	NA	72	62	51
10	NA	76	45	2
NATIONAL	84	74	61	7



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Pediatric Immunization

Commercial Childhood Immunization Status—Combination 2

Benchmarks and Thresholds *(no change from 2013)*

HHS REGION	PERCENTILES			
	90th	75th	50th	25th
1	NA	90	88	81
2	NA	86	81	78
3	NA	86	83	81
4	NA	85	84	78
5	NA	87	84	82
6	NA	82	77	69
7	NA	85	83	79
8*	NA	85	81	78
9	NA	82	81	75
10*	NA	82	80	74
NATIONAL	89	85	83	78



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Adult Preventive Care

Commercial Colorectal Cancer Screening

Benchmarks and Thresholds (updated from 2013)

HHS REGION	PERCENTILES			
	90th	75th	50th	25th
1	NA	75	68	62
2	NA	66	61	54
3	NA	67	61	56
4	NA	60	57	52
5	NA	68	59	54
6	NA	58	54	49
7	NA	62	57	50
8	NA	65	58	51
9	NA	65	60	52
10	NA	62	56	48
NATIONAL	72	66	58	53

Commercial Breast Cancer Screening

Benchmarks and Thresholds (updated from 2013)

HHS REGION	PERCENTILES			
	90th	75th	50th	25th
1	NA	82	80	76
2	NA	73	69	66
3	NA	75	71	69
4	NA	75	71	69
5	NA	76	73	69
6	NA	71	69	66
7	NA	74	72	69
8	NA	72	69	65
9	NA	77	70	67
10	NA	72	69	67
NATIONAL	80	76	71	68

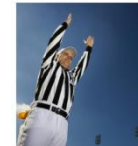


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SVHP Care Coordination Process

- ▶ Provide care coordination services across the clinically integrated network that complement the existing case management services, such as:
 - Identifying gaps in care and transition
 - Empowering the use of evidenced based care
 - Developing processes across the continuum for seamless care transition

- ▶ The SVHP Playbook
 - Identified 140+ care transitions and established baseline requirements for data portability
 - Details quality metrics agnostic to Payer
 - Reference for Care Guidelines – Preventative and disease management
 - Organizational policies and plans



ST. VINCENT'S
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Playbook

A Collaboration in Action

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Current Health Information Exchange

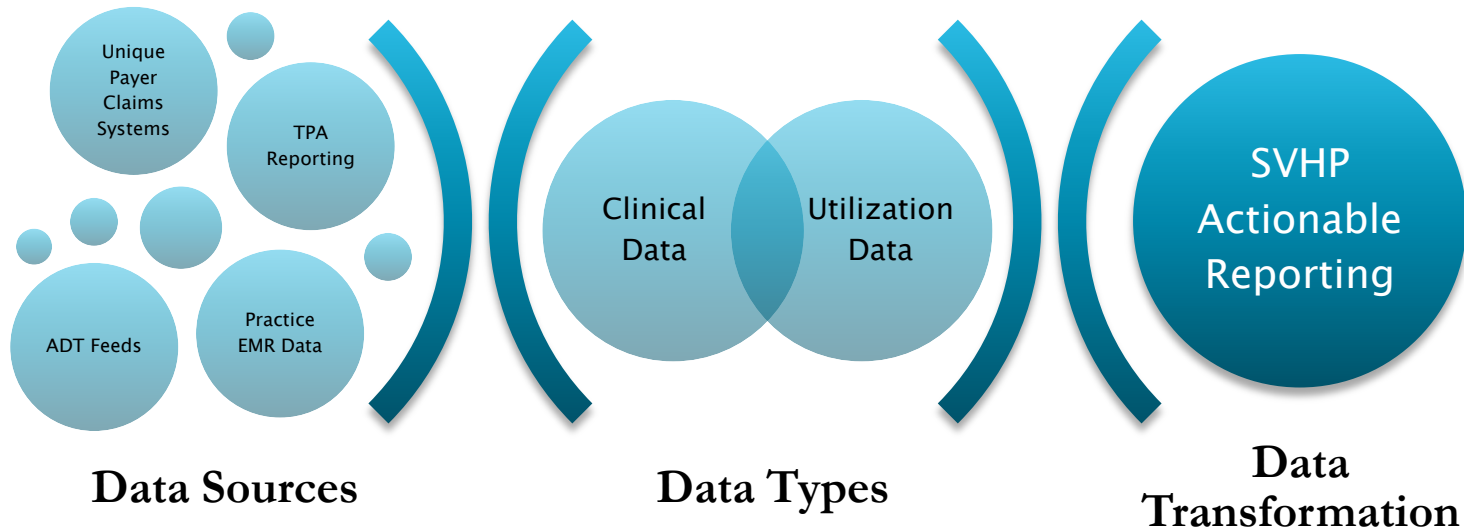


Hospitals and Health Systems



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SVHP Data Amalgamation



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SVHP Data Plan

- ▶ Secure Message all reports electronically
 - Allows onsite staff to “handle” data at highest skill
- ▶ On-site data review and collaboration
 - Review of complex patient cases
 - Review dashboards/report cards
 - Investigate and solve barriers
- ▶ Continuous communication for high profile patients
 - ED and inpatient admission
 - All inpatient discharges followed-up within 7 days
 - High risk ED discharges followed-up within 14 days
 - High readmission risk
 - Utilization



Modify filters



Patient List Report

Risk Type* Predictive

☐ Include only patients whose risk level changed
 [Deselect](#)

Normalization Method* Whole Population

Inflation Factor* 0 %

Exclude Patients No Longer Eligible No

Include New Patients Only No

Patient	Health Plan ID	Gender	DOB	Age	PCP Name	PCP NPI	Months Eligible	Age/Gender Risk Score	Normalized Risk Score (Pred)	Predicted Expenditure (Pred)	Eligible	New to Report	Prev Risk Cat	Curr Risk Cat
ADKINS, SHERMAN	01244973298	Male	02/23/1951	61	CARTER, AMANDA MD	9910954482	12	2.22	14.60	\$44,122	Y	Y		Very High
AGUIRRE, LUCIANO	01353776298	Male	01/16/1958	54	LEE, KIMBERLY MD	9985608398	12	1.18	8.60	\$26,003	Y	Y		Very High
AGUIRRE, ROSLYN	018114100QI	Female	06/25/1945	67	LEE, KIMBERLY MD	9985608398	12	2.21	11.49	\$34,734	Y	Y		Very High
ALVAREZ, SAM	31*29071909999	Male	02/27/1983	29	LEWIS, SARAH MD	9901865233	12	0.47	8.61	\$26,009	Y	Y		Very High
APODACA, LUDIE	11547547298	Female	01/22/1965	47	BENNETT, JANE MD	9976515643	12	1.44	40.42	\$122,168	Y	Y		Very High
ATKINSON, KEISHA	11307565178	Female	01/12/1988	24	WASHINGTON, RUBY MD	9944255712	12	0.67	12.29	\$37,157	Y	Y		Very High
AYERS, SHELBY	017660260QI	Male	06/12/1954	58	JACKSON, KAREN MD	9911182041	9	1.77	162.35	\$490,722	Y	Y		Very High
BACON, OMER	11307234598	Male	05/28/1969	43	GONZALEZ, MARTHA MD	9942268966	12	0.71	8.43	\$25,483	Y	Y		Very High
BADER, CLAUDE	91*45078709999	Female	12/06/2010	1	JONES, BARBARA MD	9925007313	12	0.63	15.98	\$48,297	Y	Y		Very High
BANKS, TEROME	110018543QI	Male	08/28/1962	49	GRAY, JUDY MD	9938116991	4	1.18	9.75	\$29,478	Y	Y		Very High

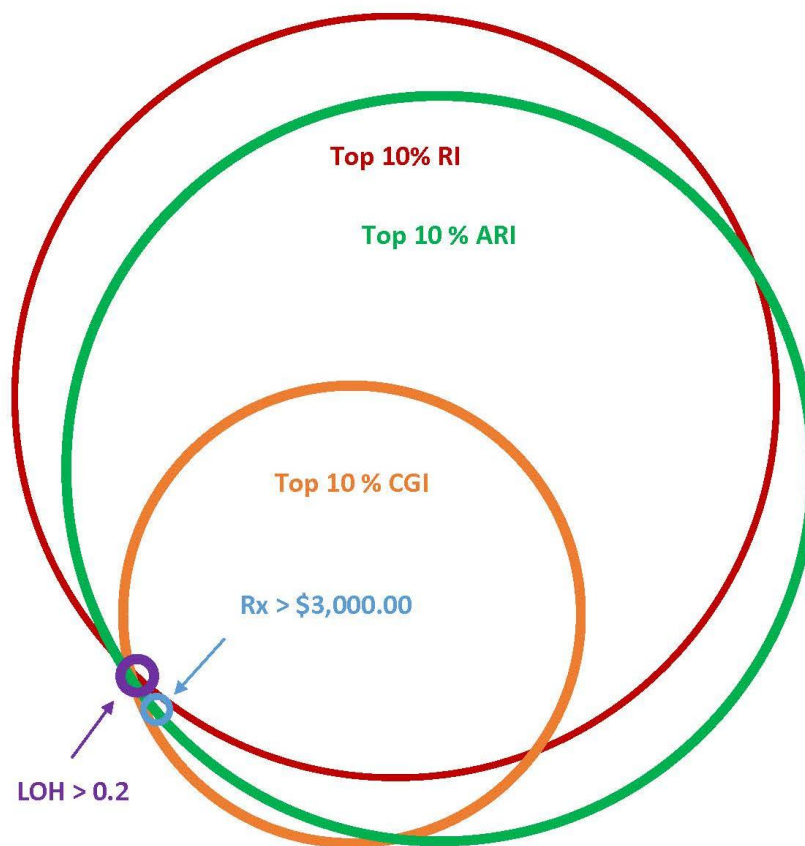
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Risk Stratification

SmartHealth Queue – By Inclusion Factor
July 2014



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Risk Stratification

Individual ID	Individual	DOB	IPP (Office/Physician most seen last month)	Total # of Queue Flags	RI (Risk Index)	CGI (Care Gap Index)	ARI (Adjusted Risk Index)	RI (Risk Index) Last 30 Days	Rx Paid	Rx Conflicts	LOH (Likelihood of Hospitalization)	High Utilizers Only - Count of Prescriptions	Narcotics Use as a % of Total Rx Claims	Top 50 Patients (by Total Rx Claims) - # of Prescribers
			VENU CHANNAMSETTY, MD	1	11	2	13	9	-	0	0.04	0	0.00%	0
			PRIMED, LLC	1	8	1	9	0	-	0	0.05	7	0.00%	0
			PRIMED, LLC	4	35	8	43	0	\$ 179.93	0	0.12	3	0.00%	0
			NICHOLAS BLONDIN	8	47	10	57	11	\$ 3,555.26	0	0.85	13	0.00%	3
			PRIMED, LLC	5	30	5	35	2	-	2	0.21	6	0.00%	0
			PRIMED, LLC	2	11	6	17	0	-	0	0.07	8	0.00%	1
			DELIA MANJONEY, MD	1	2	5	7	0	-	0	0.02	0	0.00%	0
			LEOF, FRANCINE	3	17	3	20	4	\$ 770.80	0	0.07	7	0.00%	0
			BRIDGEPORT MONROE PEDIATRIC GP	1	4	2	6	0	\$ 132.33	0	0.02	0	0.00%	0
			STUART C. BELKIN MD MICHAEL R R	1	15	3	18	4	-	0	0.11	3	0.00%	0
			CESAR A SIERRA, MD, LLC	1	12	2	14	0	\$ 106.62	0	0.07	0	0.00%	0
			PAIN & SPINE SPECIALISTS OF CT	5	36	4	40	9	\$ 431.19	0	0.27	3	0.52%	0
			PRIMED, LLC	6	40	6	46	6	\$ 191.02	0	0.26	2	0.00%	0
			TABITHA B FORTT MD LLC	2	21	1	22	0	-	0	0.02	0	0.00%	0
			None	1	1	5	6	0	-	0	0.01	0	0.00%	0
			PRIMED, LLC	2	12	6	18	0	\$ 194.01	0	0.04	0	0.00%	0
			OWEN SCHNEIDER, MD, LLC	1	10	3	13	0	\$ 168.50	0	0.03	3	0.00%	0
			PRIMED, LLC	3	32	3	35	1	\$ 6.82	3	0.06	2	0.00%	0
			CHILD GUIDANCE CENTER SOUTHERN	1	14	2	16	3	\$ 6.95	0	0.05	2	0.00%	0
			EMERGENCY MEDICINE PHYSICIANS OF	2	10	5	15	0	\$ 137.40	0	0.03	2	0.00%	0
			SEGALL, LAURENCE C	1	9	2	11	0	\$ 423.59	0	0.03	1	0.00%	0
			MEDICAL SPECIALISTS OF FAIRFIELD	6	43	5	48	56	\$ 576.70	0	0.44	0	0.00%	0
			PRIMED, LLC	2	24	2	26	0	\$ 94.07	0	0.03	3	0.00%	0
			PRIMED, LLC	1	5	2	7	0	\$ 280.15	0	0.06	2	0.52%	0

SmartHealth Queue: Attribution Data



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Risk Stratification

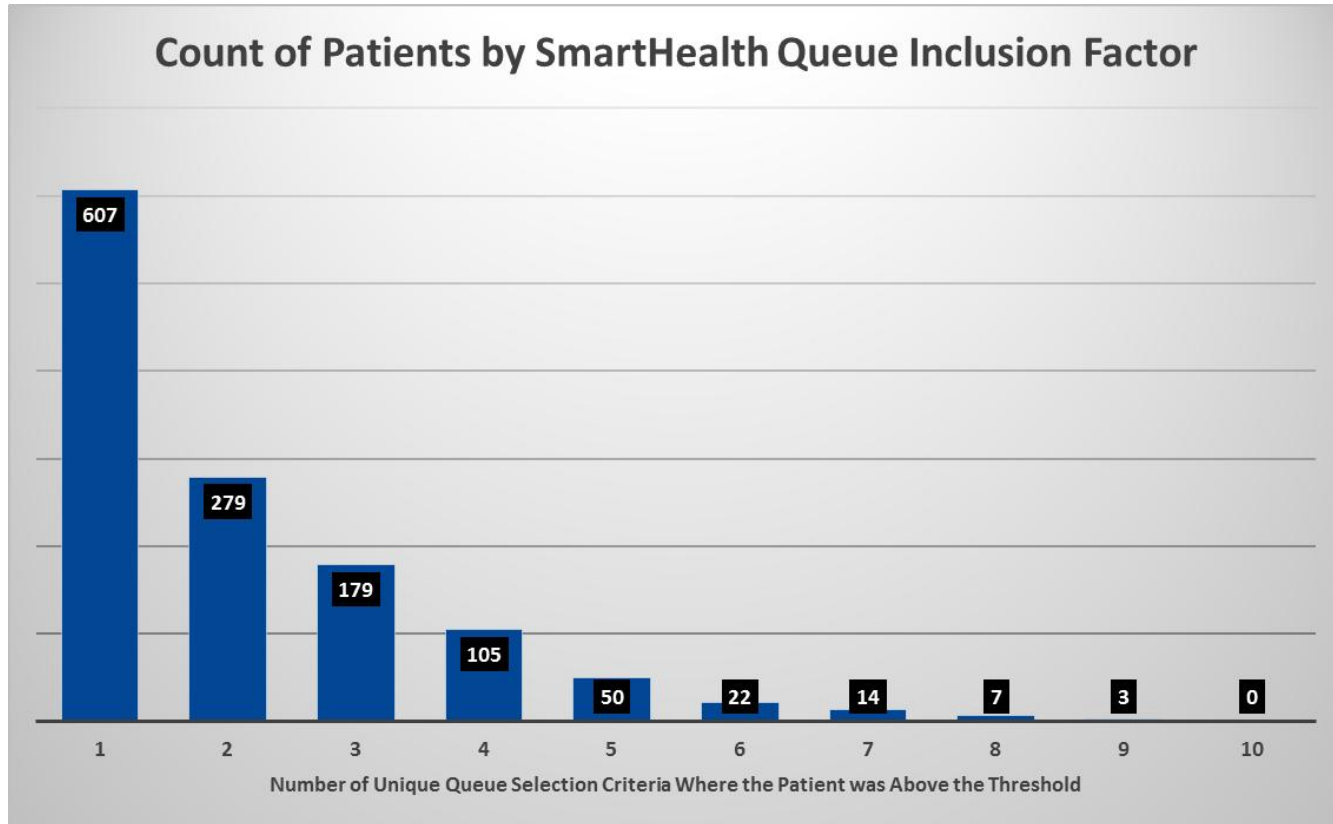
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SmartHealth Queue: Rx Data



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Risk Stratification



← Low Risk High Risk →



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Monthly Meeting with Physicians

Monthly Visit - June 2015

Monday, June 23, 2014 4:21 PM



St. Vincent's Sample Group

Visit Date:	6/2/15
Practice Personnel:	Ed Ministrator
SVHP Personnel:	Kyle Lanning

Primary Meeting Purpose:

- ☒ Monthly Review
- ☒ Quarterly Review
- ☒ Professional Relations
- ☒ Care Coordination
- ☐ Other:

☐ Follow-up from last meeting:

- ☐ PCMH process status
- ☐ Practice visit reviews
- ☐ MSG data for June - Scorecards
- ☐ Transition codes strategy meeting
- ☐ Participate in any SVHP committees

☐ New items to discuss / Education:

- ☐ Provider Scorecards
- ☐ Medicare ACO -
 - o Identified patients in ACO already; prospectively:
 - o Ensure practices have metrics
 - o Ensure practices have check off list (or in EMR)
 - o Ensure practices have tools for fall risk assessment, depression screening, etc
 - o Focus in lieu of data from the ACO -
 - o Identify patients with diabetes - process
 - o Identify results on those patients on selected metrics
 - o Assess results against metrics
 - o Go back to practices with gaps to close

Reports:

- ☐ Attribution - *Patient list*
- ☐ Prevention - *Care gaps, screenings, etc.*
- ☐ Utilization - *Care in the right place at the right time*
 - o In-patient
 - o ED
- ☐ High Risk - *At risk for decline without focused attention*

Follow Up Items:

- ✓ Follow up with top five risk patients and ensure they are getting the right care, at the right time, in the right place.
- ▶ Customize breast cancer screening letter
 - Make discussed changes and send final version (PDF) to the MD.



Reporting

Monthly Spotlight Report: June 2014 Practice: St. Vincent's Sample Group



ATTRIBUTED PATIENTS SPOTLIGHT

Risk Score > 4

Name	ID	DOB	PCP	Risk Score	High Risk	Appearing on other reports: Prevention	Utilization	Total
			ETTING, MARK D	7.56	X	X	X	4
			ETTING, MARK D	5.23				1
			ETTING, MARK D	5.04	X		X	3
			ETTING, MARK D	4.70		X		2

HIGH RISK PATIENTS

Insurer Identified

Patient	ID	DOB	PCP	Risk Score	Change	Readmission Risk	Primary Concern	Secondary Concern
			ETTING, MARK D	7.56	-23.00%	0.00%	Top 15% Risk	--
			ETTING, MARK D	7.00	0.00%	12.00%	Diabetes High Uncontrolled A1c	Erratic Rx Refill
			ETTING, MARK D	5.04	-5.00%	0.00%	ACE/ARB Medication Monitoring	Top 15% Risk
			ETTING, MARK D	4.36	52.00%	29.00%	High BMI	--

PREVENTIVE CARE

Overdue and Upcoming

Patient	ID	DOB	PCP	Status	Care Measure	Last Date of Service	Clinical Due Date	Months this Status
			ETTING, MARK D	Past Due	Preventive Screening: Breast Cancer	5/28/2015	6/28/2014	5
			ETTING, MARK D	Past Due	Preventive Screening: Colorectal Cancer	1/25/2015	9/21/2014	1
			ETTING, MARK D	Due - 30 Days	Diabetic Eye Exam	3/6/2014	3/6/2015	3
			ETTING, MARK D	Due - 60 Days	Monitoring of ACE/ARB Use	9/11/2015	11/11/2015	0

UTILIZATION

3 + Visits in the past 12 months

Patient	ID	DOB	PCP	# of Visits	Date of Visit	Treatment Facility	Primary Diagnosis	Secondary Diagnosis
			ETTING, MARK D	3	Friday, April 10, 2015	SVMC	51486 - ANTIBIOTIC RESISTANT MRSA INFECTION	--
					Sunday, July 13, 2014	SVMC	5825 - CHEST PAIN	E54689 - UNSPECIFIED PLACE
					Thursday, May 29, 2014	SVMC	2871 - ACUTE CONJUNCTIVITIS	1651 - COUGH



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Physician/Provider Dashboard/Scorecard (Quality and Utilization)

Provider Scorecard

Care Gap Performance

Dr. Sam Pell

Sample Medical Group, LLC

Measure	Rank	Out of	Completion Percentage		
			Provider	PHO Average	Benchmark
Breast Cancer Screening	10	45	85.53%	62.86%	85.63%
CAD: ACE/ARB Therapy	-	-	-	-	-
Cardiovascular Conditions: Lipid Profile	-	-	-	-	-
Cervical Cancer Screening	1	28	100.00%	74.82%	85.63%
Diabetes: Eye exam	17	37	81.25%	69.07%	82.08%
Diabetes: Hemoglobin A1c testing	20	37	87.50%	83.97%	82.08%
Diabetes: Lipid profile	-	-	-	-	-
Diabetes: Urine protein screening	21	37	81.25%	82.09%	82.08%
DMARD Therapy in Rheumatoid Arthritis	-	1	-	100.00%	85.37%
Persistent Monitoring: ACE/ARB	13	37	84.62%	57.00%	88.83%
Persistent Monitoring: Anticonvulsants	-	-	-	-	-
Persistent Monitoring: Diuretics	12	28	81.82%	63.17%	88.83%
Use of Appropriate Asthma Medications	1	15	100.00%	76.67%	85.37%
Well-Child Visits Ages 3-6 Years Old	-	13	-	67.38%	91.26%
Well-Child Visits Ages 12-21 Years Old	24	33	0.00%	40.52%	91.26%

Measure	Rank	Out of	Percentage	PHO Average	Benchmark
In-Network ED Utilization	35	53	59.00%	52.00%	-
(Reserved for future measures)	-	-	-	-	-
(Reserved for future measures)	-	-	-	-	-
(Reserved for future measures)	-	-	-	-	-
(Reserved for future measures)	-	-	-	-	-
(Reserved for future measures)	-	-	-	-	-

Data source and collection notes:	
Applicable Payer(s):	Sample Payer
Data origination source:	Sample Payer Online System
The data was pulled on:	11/4/2014
Benchmark Sources:	Sample Payer Regional Benchmark



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Care Coordination Monitoring

Date	3-Jun			10-Jun				17-Jun			
	Total	Percent	Monthly Change	Count	Total	Percent	Monthly Change	Count	Total	Percent	y Change
Care Coordination Benchmark	2826	5.00%	→ 0.34%	142	2837	5.00%	0.00%	142	2837	5.00%	0.00%
SVHP Care Coordination (Actual)	2826	12.49%	↑ 22.45%	361	2837	12.72%	14.16%	362	2837	12.76%	10.27%
High Risk Patients Touched (=>7 prospective risk)	28	100.00%	↑ 3.03%	28	28	100.00%	12.00%	28	28	100.00%	12.00%
High Readmission Risk and High Risk (Combined) Patients Touched (=>15% this week & in high risk group)	10	100.00%	↑ 12.50%	10	10	100.00%	11.11%	9	9	100.00%	11.11%
In-Patient Report: Percent of In-Patient Status Tracked Down/Confirmed	75	96.00%	↓ -4.00%	79	79	100.00%	0.00%	80	80	100.00%	2.78%
New In-Patients - PCP's Notified								1	1	100.00%	N/A
In-Patient Report: Post Discharge Appointments w/in 7 Days (SVMC Only - Excluding Direct Transfers)	35	48.57%	↓ -2.86%	No new patient data							
In-Patient Report: Post Discharge Appointments w/in 7 Days (Other Hospitals - Excluding Direct Transfers)	40	35.00%	↓ -5.00%	No new patient data				No new patient data			
Practices with PCMH Recognition (All Levels)	16	31.25%	→ 0.00%	6	16	37.50%	20.00%	6	16	37.50%	20.00%
Practices with PCMH Recognition Pending	16	6.25%	→ 0.00%	0	16	0.00%	-100.00%	0	16	0.00%	-100.00%
Practices with PCMH Recognition in Pre-Application Stage	16	62.50%	→ 0.00%	10	16	62.50%	0.00%	10	16	62.50%	0.00%



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Payor Report Card

► October
2013

► April
2014

► July 2014

Acute and Chronic Care Management	
Your earned contribution:	31.60%
Upside Shared Savings Potential:	9.00%
2.84%	

Improvement	
Your earned contribution:	40.00%
Upside Shared Savings Potential:	3.60%
1.44%	

Acute and Chronic Care Management	
Your earned contribution:	26.00%
Upside Shared Savings Potential:	9.00%
2.34%	

Improvement	
Your earned contribution:	40.00%
Upside Shared Savings Potential:	3.60%
1.44%	

Preventive Care	
Your earned contribution:	56.67%
Upside Shared Savings Potential:	5.40%
3.06%	

Utilization Metrics	
Your earned contribution:	43.98%
Upside Shared Savings Potential:	12.00%
5.28%	

Preventive Care	
Your earned contribution:	66.67%
Upside Shared Savings Potential:	5.40%
3.60%	

Utilization Metrics	
Your earned contribution:	48.35%
Upside Shared Savings Potential:	12.00%
5.80%	



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Objectives

- ▶ Review the methods that generate self-reported measures that are required for quality submission for performance reimbursement (Medicare SSP, commercial payers, Medicaid).
- ▶ How much can be automated, how much is manual, how do you address the issue of multiple EHRs? How scalable are the options for population management?
- ▶ Describe the methods for ensuring reliability and validity of the data demonstrating integrity of data.
- ▶ Describe how the data is used to support quality improvement efforts.



Questions?



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